THE RIGHT TO REFUSE TREATMENT: FOUR CASE STUDIES OF LEGAL MOBILIZATION

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This is a comparative study of legal mobilization that shows how various patterns of legal representation and layperson participation affect the scope and pace of mobilization. These patterns do not emerge from whole cloth during a particular legal mobilization but rather develop according to preexisting trends of representation and participation.

The author first discusses this analytic framework and then presents four case studies. Ultimately he presents a comparative analysis of these cases to generalize about the relationship between the patterns and the scope and pace of mobilization. He argues that patterns of legal representation and layperson participation are powerful determinants of the style and outcome of legal mobilization.

I. LEGAL MOBILIZATION

A. *Approaches to Legal Mobilization*

Mayhew's (1975) and Black's (1973) important works are both useful and limiting in the study of mobilization. They are useful because they place legal mobilization in an appropriately broad context. Mayhew stresses three factors in mobilization: the structure and organization of legal services, social networks linking legal resources to those who might be mobilized, and ideologies related to the use of law and lawyers. Most significant is his emphasis on the effect of preexisting patterns of legal services. He also points out the importance of social networks in issue development and transformation. Public policies affect the opportunities to act by structuring legal services and by encouraging or creating certain rights and claims. These policies are preconditions to mobilization (Mayhew, 1975: 420, 423).

Black more explicitly identifies the dynamics of case finding. According to him, the crucial variable in mobilization is

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how actively organizations develop cases. Do they wait for issues to come their way, or do they go out and search for problems?

Both authors see legal mobilization as a product of previously existing patterns and policies. What is lacking in both works is a sufficient appreciation of the dilemmas of legal mobilization and the role that lay participation plays. Legal mobilization is a risky business, particularly for those who see such action as only one part of a larger political agenda. The dilemmas involve the use of courts and lawyers, the scope and pace of mobilization, the degree of involvement of nonlawyers, and the trade-offs between litigation and other forms of political participation. These tensions are as endemic to mobilization as the previously discussed historical factors.

B. The Dilemmas of Legal Mobilization

Litigation is a highly structured process that defines political issues in very special, technical, and often very limiting ways and is thus easily dominated by professionals. This process is quite different from other forms of politics that are not only less dominated by attorneys but also typically less structured and less likely to require the use of a special language and esoteric techniques (Milner, 1986a).

Groups or individuals that consider using litigation as part of a political strategy find themselves asking questions about the feasibility of relying on a form of politics that stresses expertise and hierarchy. Groups that try to foster grass-roots participation feel a particular tension between litigation and the rest of their activities. This is not to say that such tension always exists but only that the relationship between layperson participation and legal representation is problematic and colors the development of mobilization.[1] Both Black and Mayhew acknowledge the existence of this tension even if they do not incorporate it sufficiently into their approaches. Black (1973: 146) makes the point that proactive legal organizations are in the best position to bring about planned change but at the same time may be isolated from citizen demands. Mayhew (1975: 404–405) sees the tension as evolving from the demands made by relatively sophisticated clientele that often characterize institutionalized patterns of legal representation. My study builds upon the insights of Black and Mayhew while developing

[1] For other discussions that consider these tensions, see Harrington (1985: 9–34).

a framework that takes into greater consideration these dilemmas of legal mobilization.

C. *An Approach That Considers These Dilemmas*

Alford and Scoble's (1969: 17, 21) comparative work on community mobilization offers a perspective that considers such dilemmas. They argue that two factors dominate mobilization: *bureaucratization,* the degree of development of specialized agencies to handle governmental functions, and *participation,* the extent to which groups or individuals have an effect on the policy-making process. The relationship between bureaucratization and participation is problematic. Participation may either counter bureaucratization or complement it to make mobilization occur more quickly. In the following analysis I use the term "legal specialization" as a subset of "bureaucratization," which Alford and Scoble use to describe more general patterns of specialization.

For comparative analysis of legal mobilization, we can consider two degrees of legal specialization (high and low) and the same two degrees of lay participation. Consider four patterns of mobilization: (1) low layperson participation and low legal specialization; (2) low layperson participation and high legal specialization; (3) high layperson participation and low legal specialization; and (4) high layperson participation and high legal specialization. To compare, we also need measures of the scope and pace of legal mobilization. Pace can be measured in two ways—how quickly mobilization began after the relevant decisions or policies were made (compare Henig, 1982) and how quickly the case moved from start to disposition. The breadth of a mobilization's scope is measured by the degree that the litigation purports to represent an individual or a collectivity like a group or a class in the legal sense of that term. Scope and pace are considered here to be the outcomes of mobilization. In my study I also consider scope and pace to vary along two dimensions: fast or slow pace and wide or narrow scope.

As I have suggested, the relationship between specialization and participation is complicated and problematic. There may be tensions over participation that affect the outcome. Mobilization might occur quickly in the absence of layperson participation because no one impinges on the lawyers' judgments. At the same time, the professional dominance of a mobilization might limit the scope because the lawyers may not feel the impetus to broaden the case. We will explore these possibilities by considering four case studies.

D. The Use of Case Studies

Each of the four case studies represents legal mobilization over the right of people involuntarily committed to mental institutions to refuse treatment.[2] These are useful cases for several reasons: They constitute a rough form of natural experiment since they all involve the same issues emerging at approximately the same time in different places. The states all had similar mental health laws that had been revised by their legislatures to be more due process-oriented, but none had explicitly granted the right to refuse treatment. (There is a partial exception, which I will discuss in the first case study.) In only one case were state laws directly involved in the subsequent litigation.

Participation and specialization have both been important issues on the agenda of mental health litigation politics. Participation has been a very salient issue for some lay organizations, especially the mental patient liberation groups whose belief in the need for deprofessionalized political activities among inmates of mental institutions has clearly affected the emergence of mental health rights (Milner 1986a, b). The four examples of legal mobilization differ widely on this dimension and on the degree of legal specialization they brought to bear on the right to refuse treatment issue.

In sum, the four cases vary on the dimensions for which my approach requires variation. Within the limits to be shown by the subsequent case discussions, they share historical and contextual similarities that often lessen the impact of comparative analysis.[3] The case studies focus on these questions: What is the linkage between participation/specialization patterns and

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[2] There is a great deal of controversy over what to call people who are committed into mental institutions. Some object to the term "mental patient" because they believe it connotes acceptance of the medical model. Others, who also disapprove of the medical model, nonetheless use the term "mental patient" because it aptly describes how these people are treated. The term "mentally disabled," although less explicitly medical, carries a connotation of helplessness and irrationality that many supporters of mental patient rights find misleading. Some use the word "inmate" to stress the involuntary and repressive nature of commitment. The battle over terms is itself a significant political issue worthy of analysis. I hedge in this paper by using various terms interchangeably. I use "mental patient" most frequently because it remains the most common term. I sometimes use "inmate" out of respect for the view that sees institutionalization as a deprivation of liberty. For variety, I occasionally use "residents in mental institutions" or "people involuntarily committed to mental institutions," more neutral but awkward phrases. I also use "mental hospital" and "mental institution" interchangeably.

[3] There are, however, some limitations that ought to be mentioned at the outset. Comparative case analysis must walk a fine line between presenting too much detail and eliminating too much detail to fit a preconceived framework. I try to minimize the latter pitfall by reporting what appears to be situational and idiosyncratic about each case, yet I organize each case pres-

the pace and scope of legal mobilization, and what process makes this linkage? The emphasis is on how preexisting participation/specialization patterns affected legal mobilization in each case.[4]

II. COLORADO: LOW SPECIALIZATION AND LOW PARTICIPATION

Although the Colorado litigation was not the first to begin among the four cases, it was the first to be completed and the only fully litigated case completed by 1983. The case began four years after the state legislature made mental health policy more rights-oriented. Only two years passed from the beginning of the case to its final disposition by the Colorado Supreme Court. Only in this state was the state legislation important to the ruling of the case, and unlike all other mobilizations, this one was heard and decided by state courts. Also in contrast to the others, the Colorado mobilization had only one plaintiff.

A. Policy Context: Legal Specialization Prior to the Right to Refuse Treatment Mobilization

In 1973 and again in 1977 the Colorado legislature had revised the mental health laws to make them more oriented to due process and rights. The right to refuse treatment, however, was not granted by these changes (COLO. REV. STAT. § 27–10.5–101, 110–130 (1973, 1977); Leidig, 1979; Colorado Department of Institutions, Division of Mental Health, 1979). However, the patterns of legal representation established by these public policies were much more significant in affecting the emergence and development of the right to refuse treatment case.

Most people who are involuntarily committed to state mental institutions are poor, so the important question in mental health litigation is typically what kinds of services the

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entation to accentuate the importance of patterns of legal specialization and layperson participation. The themes of these cases emphasize these patterns.

The case studies are pieced together from a variety of sources, some easily accessible, such as appellate court opinions and legislation, and others much less so, such as pamphlets and newsletters published by mental patient groups. Most of the latter have irregular and limited circulation. The exception is the *Madness Network News*, which is published by the Network against Psychiatric Assault in the San Francisco Bay area. It is a useful source of information on the activities of mental patient organizations that played an important role in the emergence of the right to refuse treatment mobilization. An additional source was our approximately sixty semistructured interviews with participants in the mobilization. A few field observations also provided data.

[4] See Appendix for a profile comparison of the four cases.

state makes available to such indigents. In Colorado, no policy was established to create a specialized organization of mental health lawyers. Instead, a 1975 revision of the Colorado mental health code stipulated that private attorneys should represent indigents in the mental health system (United States Department of Health, Education, and Welfare, 1979: append. A, p. 2). This pattern of representation had already been established for the developmentally disabled.

Legal aid offices in Colorado were involved some mental health issues, but these organizations had neither the structure nor the resources to bring class actions. However, by the mid-1970s they did become more cognizant of the legal complications of the actions of mental health officials. As the definition of mental health policies became more rights oriented, the legal aid offices changed their perception of their role as representatives of those in the system. A legal aid staff member in Boulder described the changes as follows: "The office moved from the role of lawyer as guardian *ad litem* under the old statute to [that of] advocate under the new one." This new orientation was also apparent in the educational and training materials made available to legal aid lawyers[5] as well as in workshops for private attorneys. Still, the focus was on the individual lawyer and the individual client.

While interest and awareness in mental health law was growing, the organization of legal representation continued to limit the scope of such cases. Class actions did not emerge even from the legal aid offices in Denver or Boulder, which were the most heavily involved with mental health litigation. According to a Boulder legal aid attorney, "We pretty much have to take all our cases as they come in." The state bar association's effort to teach private attorneys how to do civil commitment similarly did not encourage class actions (Colorado Bar, Office for the Mentally Disabled, 1978).

B. Policy Context: Lay Participation Prior to the Right to Refuse Treatment Mobilization

An equally significant factor affecting the mobilization over the right to refuse treatment was the preexisting pattern of activities by individuals and groups that might have questioned the assumptions of legal strategy. Although inventories of mental patient liberation groups claimed that they existed in

[5] According to these materials, lawyers were supposed to become less patronizing toward mental patients: "Deal with the client, that is, the person, not the 'patient' " (Colorado Bar, Office for the Mentally Disabled, 1978: 73).

both Denver and Boulder (Chamberlin, 1978), our field research uncovered virtually no such activity. We found only one respondent who attempted to develop a network with such groups. What emerged instead in Colorado was a coalition of professionals who became very familiar with each other and dominated mental health politics. As one attorney in this coalition put it, "This place [Denver] is a really small town when it comes to knowing and working with those interested in mental health policy."

Prior to the emergence of the right to refuse treatment case, then, Colorado had no specialized organization to handle the legal problems of the mental patient. Although some organizations and private attorneys became more involved with mental health issues and did so in ways that were more adversarial than they had been, the structure of legal representation still was best suited for individual attorneys representing individual clients. No groups attempted to use these resources to bring about broader forms of litigation. Mental health legal activities were primarily in the hands of small coalitions of professionals who were able to work out their differences and who were not challenged by outsiders. Class action litigation was not part of their arsenal.

C. *Legal Mobilization and the Right to Refuse Treatment*

From the start, the traditional structures of legal specialization and lay participation in Colorado played key roles in keeping the right to refuse treatment mobilization narrow, straightforward, and rather uncomplicated. The mobilization began in late 1976 when Ralph Goedecke, the future plaintiff, called the Boulder legal aid office. Goedecke was a loner who was isolated from others at the institution where he was diagnosed paranoid schizophrenic. He had taken Prolixin, a common antipsychotic drug, but subsequently refused to continue to take this medication because of its side effects. He was assertive enough to put a note to this effect in his record. His doctors responded by forcibly injecting him with long-term doses of the drug (*Goedecke* v. *Colorado*, 603 P.2d 123 (1979)).

According to one of the legal aid lawyers, the Boulder office "had become aware of the harmful effects of antipsychotic drugs and was alert to the fact that we might find a client who would object to the medication." The same was true of the Denver legal aid office, which ultimately was also involved with the case. Despite this interest and anticipation, however, the mobilization process was reactive. A Denver attorney claimed

that "it was hard to get a clear-cut case," which was no doubt true, but this view assumed a form of case development and management that was limited in its ability to gain access to the institutions that were the potential sources of many such cases. The acceptance of the difficulty of getting clearly defined cases indicated that there was no developed social network linking mental health lawyers to the inmates of the mental institution.

After talking to Goedecke, the Boulder legal aid office decided to follow the usual pattern in mental health cases with potentially broad policy implications: The office asked a private attorney to handle the case as a volunteer. This attorney was politically and highly visible in the Denver-Boulder area, but he had no experience in mental health litigation. This lack of experience, combined with the absence of resources for legal representation, reduced the likelihood that the case would broaden in scope.

No new lay groups emerged to play key roles in the mobilization. The well-developed network of professionals that existed prior to the Goedecke litigation dominated the development of the case. While not all members of this coalition had the same degree of faith in the due process orientation that mental health policy had developed (see, e.g., Warner and Yaeger, 1980), this group was able to agree upon an approach to the right to refuse treatment. The coalition included legal aid attorneys, the American Civil Liberties Union, physicians, and the Mental Health Association of Colorado. The latter acted, in the words of one of its staff, as "mediator of the coalition." With the addition of a University of Colorado law professor who had some knowledge of mental health law, the group was in place by 1976.

The coalition specialized in lobbying, and of course some members had a good deal of litigation experience, although they had never developed links with those inside the mental institutions. Consequently it did not seek out others with complaints similar to Goedecke's. The lack of layperson participation further reduced the likelihood that case finding would take place.[6]

Other events and tactics that were not directly linked to patterns of representation or participation affected the scope of the case by keeping it quite clear-cut. The state mental health

[6] This pattern of professional domination continued even after the Goedecke case was decided. A few months after the Colorado Supreme Court handed down that decision, the Boulder Mental Health Center held a "mental health and the law" symposium at which all the speakers were medical or legal professionals (see Boulder Mental Health Center, 1980).

bureaucrats who were defendants in the case were initially unsophisticated in their response to Goedecke's allegations. One example of this was described by the trial judge:

> The lawyer for Goedecke on Friday afternoon filed an injunction to stop the use of drugs. I never do anything without hearing from the other side, so I called the psychiatrists at the institution. "They did not need to come to court," they said. So I granted an injunction. Then they wanted a hearing. (interview with author)

The psychiatrists remained resentful and unsophisticated throughout the rest of the trial. They were never prepared to rebut the testimony of the plaintiff's experts regarding the side effects of the antipsychotic drug.

The substance of the state's mental health laws also played a role in the routinization of the right to refuse. The law declared that its purpose was to provide the fullest measure of dignity, privacy, and "other rights" to people facing commitment and continued institutionalization (COLO. REV. STAT. § 101 (1973, 1977)). Goedecke's lawyer decided that this general declaration of rights was sympathetic enough to be the basis of his case. No constitutional issues were raised, and the case was tried in the state courts.

On the whole, however, the substance of this statute had a minor effect on the scope of the case. Even if the law was clearly sympathetic—and that certainly was debatable, particularly at the outset of the case—a class action could have been brought to take advantage of this law.

Goedecke won at the trial level. The state mental health bureaucracy belatedly realized the importance of the case and appealed. Goedecke won on appeal also. The Colorado Supreme Court opinion also showed how straight forward and narrow the case was, for it relied entirely on state statutes. More significantly, it did not establish any procedures for determining whether Goedecke was competent to make a rational judgment about his drug regimen. If a class had been involved, such procedures would have been unavoidable. The court simply said that the record did not show that he was incompetent to make such a judgment and that the thrust of Colorado law gave the benefit of the doubt to maintaining the rights one had before he or she was placed in a mental institution.

Traditionally, mental health litigation featured little legal specialization and no layperson participation. This pattern continued during the mobilization even though legal organizations and some individual practitioners became more cognizant of

mental health law, adopted a more adversarial posture, and anticipated that the right to refuse treatment would emerge as an important issue in Colorado. Because these patterns held for the right to refuse treatment litigation, there were limited resources for class action and little pressure from outsiders to broaden the case. From the beginning the attorneys defined the case narrowly. They were interested in state statutes and one individual. The substance of the law, combined with the tactical errors of the defendants, made the success of the lawyers' strategy more likely, but that strategy had initially emerged from the structure of legal representation.

III. NEW JERSEY: HIGH SPECIALIZATION AND LOW PARTICIPATION

The Appendix indicates that although the New Jersey and Colorado cases began at about the same time, their pace, scope, and disposition were quite different. The New Jersey case formally began two years after the state legislature adopted its more rights-oriented approach to mental health policy. The litigation started as a suit brought on behalf of an individual. The federal district court's initial ruling, a temporary restraining order against a New Jersey state mental institution, applied only to that individual. Ultimately, the scope changed as the case developed into a class action on behalf of all the inmates in the New Jersey mental institutions and was appealed to the United States Supreme Court.

Of all the legal mobilizations, New Jersey's had the greatest degree of legal specialization, and this pattern of specialization had dominated the state's mental health litigation prior to the emergence of the right to refuse treatment case. As in Colorado, the New Jersey mobilization had very low levels of lay participation.

A. *Policy Context: Legal Specialization Prior to the Right to Refuse Treatment Mobilization*

As part of its mental health law reform, the New Jersey legislature established a statewide public advocate's office that included an office of public advocate for mental health, which was mandated to provide legal services for indigent mental hospital admitees on issues pertaining to admission to, release from, and confinement in mental institutions (N.J. STAT. ANN. § 30:4–24.1 (West 1981)). From its inception in 1974, the public advocate's official activities included both class and individual actions. This program was unique in its mobilization of

state resources for such class actions (Perlin and Siggers, 1976). This concern with class actions spilled over into other related areas. Unlike most states, including all in the present study, the New Jersey state protection and advocacy plan for the developmentally disabled specifically mentioned class actions as part of the program's mission (American Bar Association Commission on the Mentally Disabled, 1978).

By 1975 the public advocate for mental health directly represented six of the state's twenty-one counties, including the two most populous. The class action section, with its 2.5 attorney positions, represented the entire state.[7]

Two characteristics of the public advocate's office profoundly affected the way mental health litigation developed. One was the creation of the class action office. The state mental health advocate did not want class actions to dominate the agenda for fear that the office would become isolated from the everyday problems of the institutionalized individual. Nonetheless, the advocate's office saw class actions as an integral activity, and class action specialists played an immediate, crucial role. The first class action was filed very soon after the office was established. Prior to the right to refuse treatment litigation, the class action staff handled two cases that the director considered to be very significant (Perlin, 1981). According to the state public advocate for mental health, by 1980 the office was receiving approximately six hundred requests a year for class action litigation. Each attorney handled only two or three full cases a year, so an informal but fairly explicit set of case selection criteria developed.[8]

The second part of the pattern of specialization that greatly affected legal mobilization was the availability of field workers who had systematic and regular access to both the staff and patients in the mental institutions. From its inception, the public advocate's office staff included nonlawyer professionals with extensive experience in the mental health field. Our interview-

[7] There were other indicators of a high degree of legal activity in New Jersey. Studies by the United States Department of Health, Education, and Welfare (1979: 13) as well as the American Bar Association Commission on the Mentally Disabled (1978) suggested that more private attorneys in New Jersey were developing some mental health law skills than were their colleagues elsewhere. Bar-sponsored mental patient representation programs were expanding in the state at the same time they were contracting in other places.

[8] The state Advocate for Mental Health listed the following criteria for choosing class action cases: the possibility of serious injury to a client; an issue that cannot be resolved out of court; a case with significant impact; a problem that another agency cannot handle; a case that is winnable; and a case that can be handled with the available resources.

ees stressed the extent to which the office combined legal and mental health expertise.

Much of these field workers' time was spent on the wards, where the patients were typically eager to talk to them. They heard the patients' complaints both firsthand and from sympathetic staff. As one field worker stated, "The field reps are a friend, a resource, an ear. They are on the side of the patient." Their advocacy role was strengthened by their access to hospital records. The field workers in fact handled most problems that emerged from the mental institutions. They acted as both gatekeepers and case finders for the attorneys, especially when the class action lawyers were trying to establish a class.

This organization of the mental health advocacy office also had a more subtle impact on the development of cases. According to its director, the interaction of lawyers and nonlawyers forced the attorneys to learn from other professionals and was thus a "political move" as the lawyers became more aware of the political implications of their cases (Perlin, 1981).

B. Policy Context: Lay Participation Prior to the Right to Refuse Treatment Mobilization

Laypersons did not play a significant role in this continuing effort at law reform. Mental patient liberation or self-help groups were not in evidence in New Jersey during the years between the key changes in the mental health law, the formation of the public advocate's unit, and the emergence of class actions in mental health rights cases. This was despite the fact that the director of the public advocate's office was nationally known and appeared on panels with members of such groups from other states. There was, however, a very active mental patient liberation group and an exceptionally strong network of sympathetic lawyers in Philadelphia, just thirty miles from the public advocate's main office in Trenton.

Part of this absence of participation stemmed from the strategy adopted by the public advocate's office. Much of its strength came from its close ties with other state agencies, which gave it good entrée to the patients as well as legitimacy. The staff's success as insiders would have been threatened by similar ties to other, outside groups. As one of the high-level staff members put it, the office "did not want to come across as radical like the ACLU or other types of political organizations."

A more important reason for the lack of lay participation was rooted in the structure of legal representation, which institutionalized the links between the lawyers and their potential

clients. Because there was a field staff with good access to the mental institutions, the attorneys did not feel the need to ask these groups to become case finders.

C. *Legal Mobilization and the Right to Refuse Treatment*

Despite the legal structure's capacity for broad action, the mobilization that was to become the *Rennie* v. *Klein* case (476 F. Supp. 1294 (D.N.J. 1979)) started with a very limited scope. It began without any initiative from the public advocate's office. As one of its attorneys described the first involvement, "We fell into the *Rennie* case. It [the initial contact with Rennie] was an eleventh hour call from Rennie saying that he did not want to take his medication." Rennie had had no previous contact with the advocate's office, although he claimed that he had wanted to call earlier but could not get permission from the institution's staff.

Although he was probably more assertive than most mental patients, Rennie shared many of the characteristics common to the chronically mentally ill. He was in and out of mental institutions. Sometimes he would take his medication, and other times he would refuse. At times he would quit taking the drugs once he was released.[9] Occasionally he was violent. His last admission to the hospital before his call to the public advocate's office was in 1976, about a year prior to his first contact with that office. The length of this 1976 commitment indicates that the hospital staff was pessimistic about his prognosis. They saw him as a highly assertive, frequently irrational patient who was becoming uncontrollable more and more frequently. In short, Rennie had had a classic confrontation with the staff because he was so much like the inmates they feared and because their response to him—refusing his request for other forms of treatment and increasingly restraining his behavior—was so much like the actions that mental health rights advocates saw as common, callous, self-defeating, and ultimately unconstitutional.

Nevertheless, the initial response to Rennie's case was narrow and nonadversarial. Although he was not willing to take Prolixin, which his psychiatrist admitted gave him severe side effects, he was willing to take another medication. Consequently, after filing suit but prior to any trial, the advocate's office negotiated an agreement between Rennie and the hospital.

[9] His history is described in *Rennie* v. *Klein* 476 F. Supp. 1294 (D.N.J. 1979).

All parties agreed to try an alternative medication. This action focused the case on a single situation and temporarily deflected it from broader mobilization. An important point of contention remained, however: whether the doctors could later forcibly give Rennie an antipsychotic drug more like Prolixin if they thought that such medication had become necessary. Therefore the case went to trial.

At first the primary question was whether the doctors could change Rennie's medication forcibly. Thus, the scope of the case had widened a bit, but it still involved only a single mental patient. Rennie's situation then required more immediate attention because his agreed-upon drug was no longer effective. As a result, the hospital went to court to remove the court order based on the early negotiations. Both parties agreed to give this alternative drug regimen one more try, but by May 1978, less than a month later, Rennie and the doctors were back in court arguing over whether he could be forced to take another medication. By now it had become increasingly clear to all parties, including the judge, that individualized negotiations were not going to work. Some broader principles were at stake, and they had to be faced directly if the conflict was to be resolved.

It was at this critical stage that the preexisting patterns of legal representation and participation had a key influence on the case. The advocate's office applied its class action criteria to the Rennie case and decided that it was an excellent case to pursue.[10] There was the possibility of serious injury to those who were medicated against their will. It had become clear that the issue could not be negotiated. The case, in the opinion of the office, would have a significant impact on law reform. Finally, the class action office had the resources to pursue the case, including the field workers who could act as case finders.

The case was handled entirely by the advocate's lawyers and field staff. Although the state public advocate became part of an emerging visible network of lawyers interested in the right to refuse treatment, these other attorneys played no direct role. In Philadelphia during this same period, several attorneys were involved in a pathbreaking case involving institutions for the mentally retarded, a case that increasingly served as precedent for mental health right to refuse treatment cases, including the one in New Jersey (*Pennhurst* v. *Halderman*, 451

[10] For these criteria, see n. 8 above.

U.S. 1 (1981)). In addition the mental patient liberation groups in Philadelphia, which were among the most active in the United States, had become embroiled in a legal controversy that had its roots in the right to refuse treatment.[11]

Mental patient liberation organizations barely had the resources to deal with issues in their own communities, much less elsewhere. Again, however, the more important reasons for their noninvolvement stemmed from the structure of legal representation. The New Jersey advocate's office had adequate resources and sufficiently institutionalized legal representation to handle the case without outside assistance. Here the ability to find participants in the class action was crucial. The New Jersey advocates did not need mental patient liberation groups to make contact with those inside the institutions' walls. In effect the state's lawyers had their own case finders paid for at state expense.

The structure of the legal representation also affected the relationship between the New Jersey litigators and outside attorneys. By the time the Rennie case became a class action, the state had a small but highly visible group of mental health lawyers with national reputations. Most of these were or had been associated with the Mental Health Law Project (MHLP), the leading source of information and litigation assistance regarding mental health law. As we shall see in the Massachusetts study, attorneys who initiated cases were often ambivalent about bringing Project lawyers into their cases. The MHLP had the resources and expertise, but the lawyers who brought the original cases worried that they and their clients would lose control to attorneys who were too concerned with establishing broad principles and too little concerned with solving the problems of the individual. Key people in the New Jersey advocate's office felt this way about the MHLP (Perlin, 1981). Because the New Jersey organization had the structure—class action specialists with close involvement with individual cases—and resources both to broaden and develop cases, it did not feel the need to use the MHLP.

Despite these impressive resources, the development of the class action encountered obstacles that slowed the case down. Even with the availability of case finders, it was still difficult to get a group of vulnerable, isolated, and often difficult people to

[11] We interviewed extensively in Philadelphia. None of the respondent lawyers or liberation group members mentioned participating in the *Rennie* case.

become part of a lawsuit. In what a trial court judge later described as "representative" of the way New Jersey mental institutions operated (*Rennie* v. *Klein* 476 F. Supp. 1294), hospital employees punished a person who complained to a public advocate staff member about the painful side effects of drugs by not allowing that patient to switch to an alternative medication. Even if they did not face such reprisals, the inmates were sometimes reluctant to get involved. Those who chose to do so had, according to a field worker from the advocate's office, more assertiveness and efficacy than the average inmate. They were "more radical than the typical patient. They were white, more verbal, more educated, and less fearful of the system. Many led middle class lives before 'going crazy.' "

In addition, the broadening of the case meant that the plaintiffs' lawyers needed more time to make a case that was comprehensive enough to apply to all the relevant members of the class and that raised all the important issues that made it a worthwhile attempt at law reform. For example, a key issue became the effects of antipsychotic drugs in general rather than just the drugs that Rennie took. Twelve days and 118 witnesses were needed to hear all the testimony on this point (Perlin, 1981).

The scope of the case was also broadened by the original decision to pursue the issue through the federal courts. Neither New Jersey statutes nor the state constitution was seen as sufficiently encouraging of the right to refuse treatment. The trial court's decision did not satisfy either side's view of what general procedures for dealing with the issues should be. The district court ruled that there was a right to refuse treatment under some circumstances and that a hearing was necessary if the doctor and patient disagreed over a drug. The mental health advocate's office decided to appeal this ruling because it also required that a hearing to determine whether a patient was competent to refuse treatment be governed by a psychiatrist from outside the institution who would have final authority. To the advocate's lawyers, this continued to put too much control in the hands of psychiatry. On the other hand, the state appealed because it objected to the declaration that there was a general right to refuse treatment.

The case broadened into an attempt at comprehensive law reform through class action, then, not as a result of outside pressure by groups of mental patients or their supporters but because the mental health advocate's office, which monopolized the decision-making process, had sufficient resources, expertise, and interest to develop the case in this way.

IV. MASSACHUSETTS: HIGH SPECIALIZATION AND HIGH PARTICIPATION

The mobilization that became the *Rogers* case in Massachusetts began in 1975. Although this was the earliest of our four cases, it occurred five years after the important changes in the state's mental health laws. The case had been decided by the federal district and circuit courts by 1980. Soon after, the United States Supreme Court granted certiorari, and in June 1982 that court remanded the case to the Massachusetts courts.

Prior to mobilization, there was a well-developed but small network of mental health attorneys in Massachusetts. Although the state's patterns of legal representation were not as centralized as they were in New Jersey, there were some institutionalized, government-supported mental health legal services programs with extensive class action experience and staff. The lawyers and staff in these programs collaborated with other mental health lawyers in Massachusetts. The Mental Patient Liberation Front (MPLF), a liberation group founded in the early 1970s, was also very active prior to the emergence of the right to refuse treatment case, building coalitions with sympathetic professionals, advising lawyers, engaging in more confrontational forms of politics, and raising consciousness.

A. Policy Context: Legal Specialization Prior to the Right to Refuse Treatment Mobilization

The most influential specialized legal organization was the Western Massachusetts Legal Services project in Northampton State Hospital. This program began in 1972 as part of a federally funded legal services project. By 1975, the state hospital organization was an autonomous enterprise with highly institutionalized access to the patients in Northampton. The bulk of the staff time was spent on individual problem-solving and individual cases, but this organization, which ultimately became known as the Mental Patient Advocacy Project (MPAP), did a great deal of what it described as "law reform efforts," including class actions involving federal constitutional issues. Paralegals played crucial roles in linking patients to lawyers in these cases.

Although the jurisdiction of the MPAP formally included only Northampton, informally that organization became the center of a statewide network of litigators and interest groups. Not long after the MPAP's inception, its staff began to search for an important case with statewide implications. After it received a grant from the National Institute of Mental Health in

1976, the MPAP, in the words of a staff member, "went looking for a case" that thoroughly challenged the state's mental institutional practices and, with the help of the state's Mental Health Association, found one. It became a comprehensive class action suit that sought to deinstitutionalize or at least find less restrictive facilities for the mentally disabled throughout the state. The case was finally settled by a consent decree that sought to touch upon not simply aberrant official behavior but also the everyday activities of all state mental institutions (*Brewster* v. *Dukakis*, No. 76-4423-F (Mass. Dist. Ct. 1978); United States Department of Health, Education, and Welfare, 1979: append. A, pp. 13–14).

This lawsuit did not so much create an advocate's network as it did reinforce the existing one. Boston Legal Services, which became an important player in the right to refuse treatment case, had already assigned someone to handle cases in Boston State Hospital almost full-time. Nonetheless, early on, the key to the case was the MPAP, which a federal program assessment considered to be "one of the foremost external patients rights programs in the country" (United States Department of Health, Education, and Welfare, 1979: appen. D, p. 12). By the time the deinstitutionalization suit had emerged, the chief attorney at the MPAP had worked closely with his colleague in Boston Legal Services. An MPAP staff member described the Boston-Northampton relationship as follows: "They work closely together with each other. They talk over strategy and how to use each other's talents. They also write briefs together and work on class action suits."

The state judiciary encouraged advocacy networks in explicit if not very militant ways. In 1970, the judiciary created a committee of lawyers to monitor the changes in Massachussetts's mental health laws. While the state's reform-oriented attorneys described this committee as a very cautious organization, the committee played a role in developing a broad coalition representing a spectrum of groups, including the MPAP.

B. Policy Context: Lay Participation Prior to the Right to Refuse Treatment Mobilization

Massachusettes, particularly the Boston area, was one of the strongholds of mental patient liberation groups. The MPLF was the most active and influential of these groups. Its most visible spokesperson was Judi Chamberlin, a frequent and insightful writer on mental patient liberation (Chamberlin, 1978). There were other sympathetic organizations, like the

Elizabeth Stone House, that shared many of the MPLF's ideologies and interests (Raffini, 1975).

The MPLF, like other liberation groups, wanted to eliminate all involuntary treatment and to create instead small, voluntary, democratically run, coercion-free settings that were not controlled or dominated by mental health professionals. Litigation was an acceptable tactic for working toward these goals. After a brief period of optimism in the early 1970s, it became apparent to the MPLF that no one was going to develop, much less win, a lawsuit invalidating involuntary commitment, so the group adopted a strategy of trying to make it as difficult as possible for mental hospital staff to keep a person inside an institution once he or she was committed.

Demonstrations, more than lawsuits, brought the MPLF to the attention of the community at large as well as to state mental health officials. According to an MPLF member, "We have always had a core group of about ten members who do the organizing. But when it comes time to demonstrate, we get as many as a hundred ex-patients." These demonstrations became part of a multifaceted set of tactics used by the MPLF to influence policy makers as well as legal and medical professionals. The MPLF approached such official politics with a good deal of skepticism.[12] Considering its financial marginality as well as its grass-roots, democratic ideology, it is not surprising that the group focused on more confrontational politics.[13]

C. Legal Mobilization and the Right to Refuse Treatment

Despite this well developed and institutionalized network of legal representation, the right to refuse treatment mobiliza-

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[12] See Chamberlin's strong condemnation of the final product of a "blue-ribbon" mental health commission of which she was member, quoted in Blue Ribbon Commission, 1981: 245.

[13] The following description from one of our field workers illustrates how these tactics worked:

> The MPLF sought a confrontation with Mills [the new mental health commissioner]. There were about thirty MPLF members at the meeting. They were well organized and had role-played the meeting, taking turns playing Mills. They wanted a clear if small victory, i.e., that Mills would promise to see that the state regulations were followed in respect to the law and that the rights of patients be displayed publicly on the floors of the mental institutions. They also wanted him to post a list explaining the negative side effects that drugs could cause. Mills would not allow the meeting to be taped. He said he wanted it to be friendly and informal. The MPLF began right off by stating their demands. During the meeting Mills insisted that he could make no promises and that though he generally agreed with the MPLF's concerns, he would have to consult with his legal staff. He wanted not to have to confront the MPLF, but they pushed him hard. He did not lose his cool, but he did earn his pay that day.

tion in Massachusetts began in a dramatic way without lawyers. It was initiated by a small group of inmates in two units of Boston State Hospital. By 1974, this group was meeting regularly to investigate staff mistreatment of fellow mental patients. The group, along with others in the same units, began to define forced drugging as the basic problem, and became visible and unified enough to be labeled the "Boston State Seven" (*Madness Network News*, 1975).

In April 1974 this group invited the MPLF to help with organization and consciousness raising. The MPLF appeared, and the inmates asked them to come back weekly. The hospital staff then tried to disband the "Boston State Seven," which had grown larger and quite visible outside of the institution. Eighty percent of the mental patients in Boston State Hospital signed a petition asserting that the group should be allowed to continue (ibid.). With the help of the MPLF, the group sent petitions to both the public and the hospital staff. Seclusion and forced drugging were the most frequent complaints.

Before any attorneys became involved, then, a group of assertive and experienced mental patients had defined their problem in a way that was conducive to mobilization over the right to refuse treatment issue. In addition, this group was allied with an organization with equally strong views on both the right to refuse treatment and the importance of mental patients participating in decisions that affected their lives. Finally, forced drugging was already seen as a collective rather than an individualized problem.

A lawyer did not become directly involved in the case until January 1975, almost a year after the patients' initial organizing. That lawyer was the Boston Legal Services attorney who was the regular representative for those inside Boston State. In April 1975, this attorney began the ultimately unsuccessful negotiations with the hospital. While the staff would agree to change its behavior regarding some individual patients, the lawyer and the staff could not agree on more general rules. The hospital also refused to give up the right to make exceptions even in cases in which individual agreements had been negotiated.[14] Less than a month after the negotiations began, the original group of seven filed suit. Both the patients' organizational strength and the increasing visibility of the issue were important in getting the suit filed so quickly. The attorney felt

[14] This is summarized in *Rogers* v. *Okin* 478 F. Supp. 1342 (D. Mass. 1979).

that he had to sue at that time to maintain credibility with the patients and the hospital staff.

Once the case was filed the dominant preexisting legal network and patterns of strong layperson participation emerged. From the outset, the Boston lawyer worked very closely with his Northampton counterpart. Both had the same opinion on the issue, had ambivalent views about class action, and, most significantly, at the earliest stages of the case, had good access to their respective mental institutions. They also shared the belief that nonlawyers and nonlegal definitions of the problem were very important.

The attorneys first concentrated on the formal plaintiffs in the case, although they tried to develop the litigation so that the court decision would apply to all state mental institutions in Massachusetts. The scope and the pace of the early developments were very much affected by the existing patterns of representation and participation. The decision to go to federal court was based on the success that the Northampton legal organization (MPAP) had had in earlier class actions. The initial scope—no class action and a focus on the right to refuse treatment—stemmed partially from this deference to the MPAP, which saw the problem as a collective one but worried about the loss of control if the case were extended too far.

Nevertheless, the case broadened in scope after a temporary restraining order against the state mental health official was granted, and in October 1975 the case officially became a class action. One reason for the change was that resources became available. Despite its class action experience, Boston Legal Services faced some important resource limitations. As one staffer put it, "It [the case] took away resources from other social issues." The cooperation of other legal organizations alleviated these problems. National mental health rights organizations like the ACLU and the MHLP, which encouraged the development of a class action, offered their services.

This movement to class action was not without conflicts, because the Massachusetts attorneys worried that they would lose control of the issues to the outside litigators and that the concrete problems of the original plaintiffs would get lost in the shuffle.[15] Although the MPLF agreed that the case had broad

[15] It is interesting to note how often mental health lawyers in this state expressed misgivings about class actions even as they developed what promised to be one of the most significant such actions in mental health law. Some of these misgivings may have been second thoughts resulting from the changing times, because by the time our interviews were conducted, these attorneys had faced serious obstacles in implementing class actions that applied to mental institutions. Also, as we shall see, legal reformers became increasingly

implications, it too had misgivings about a class action. The MPLF was also concerned that the local groups, especially the original litigants, would lose control, but, more significantly, it was skeptical about any involvement because the MHLP, unlike MPLF, did not rank the end to involuntary commitment as a high priority. As a result, the MPLF questioned the MHLP's commitment to the case. As one MPLF member stated, "The early suits were filed independently of the MHLP, which only became involved in the area later. The right to refuse became a high priority within the MHLP only when it clearly was not going to go away" (Chamberlin, 1983).

On the other hand, there was a strong impetus for a class action. The case was important, and it raised all of the right issues. The MPLF decided to go along with the class action but to adopt a strategy that would take its misgivings into consideration. This strategy centered on the MPLF serving as an intermediary between the lawyers and the original plaintiffs and then between the lawyers and other members of the class. As one attorney described this role, "I often used the MPLF as a consulting and mediating arm and to get the patients to talk to me about hospital problems."

This description of the roles of the MPLF or the patients is a bit too simplistic. Tensions over the nature of class actions continued once the decision had been made to broaden the scope of the case. When the Massachusetts attorney general's office initially tried to settle the case by agreeing to accede to the complaints of physical seclusion in exchange for the plaintiffs' dropping the monetary damages part of their suit, the patients differed with their lawyers over what to do. The mental patients did not want to give up the possibility of monetary relief and thus refused to negotiate on these terms. The lawyers felt that receiving damages was far less significant than establishing a right, but they deferred to the patients through the early stages of the case.

When the patients lost on the damages issue in the federal district court, the attorneys reluctantly appealed on this issue. When they lost again at the appellate level, the patients agreed to drop damages for two important reasons. First, by now all parties agreed that the case had potential for the United States

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pessimistic about the federal courts' amenability to such cases. These misgivings may also have arisen because, even after the case expanded in scope, there was a pervasive feeling that the really important (if often unsung) work took place in the trenches. This view reinforces the belief that the clients should be able to define their interests.

Supreme Court, and they did not want that court to set a bad precedent on the damages issue. Second, the MPLF was instrumental in legitimating the dropping of this claim, which the MPLF felt was secondary and perhaps counterproductive, so that the organization was willing to raise the issue with the litigants.

As the case began to show real potential as a law reform suit with national implications, the participation of other groups increased. Amicus briefs were filed by the MHLP, the national office of the Mental Health Association, the New York office of the ACLU, and the American Orthopsychiatric Association. But for reasons that had nothing to do with patterns of participation and legal representation, the scope of the case narrowed. Both the trial and appellate courts agreed that there is a right to refuse treatment in nonemergency situations (*Rogers* v. *Okin* 478 F. Supp. 1342 (D. Mass. 1979)). The state of Massachusetts appealed the case to the United States Supreme Court.

Initially, the patients' lawyers and the MPLF welcomed the appeal because they wanted to make the case as broad as possible and because they thought that the Court would be reasonably sympathetic at least to the idea of declaring that the right existed. By the time the case was actually filed in the Supreme Court, however, the lawyers were no longer optimistic because in a recent case the Court had been unwilling to expand the rights of those in institutions for the mentally retarded (*Pennhurst* v. *Halderman* 451 U.S. 1 (1981)). At the beginning of the case, the lawyers had assumed that the federal courts offered them their best chance. Now that choice looked much less inviting. Consequently the Supreme Court brief filed in behalf of the patients raised the possibility that a recent Massachusetts decision suggested that that state's constitution justified a right to refuse (*In re Roe* 421 N.E.2d 40 (1981)).

If it had been business as usual, the attorneys would not have made this point because it jeopardized the likelihood that the Supreme Court would rule broadly. To protect their case, the lawyers filed a motion calling this newly decided state case to the attention of the Court. In effect the Court responded positively to this motion by remanding the case to the appellate court to consider whether the Massachusetts law furnished the relevant standard. Justice Powell also hinted that if the patients had to rely on a Supreme Court interpretation of the right to refuse treatment, they probably would not come out very well (*Mills* v. *Rogers* 102 S. Ct. 2442 (1982)).

V. CALIFORNIA: LOW SPECIALIZATION AND HIGH PARTICIPATION

The scope of California's mobilization narrowed considerably as that case developed. In addition the pace of the case was quite slow; there was never much momentum. Five years after the original filing, the case had still not come to trial. It was finally settled with a much narrower scope than it had had at the beginning.

California falls within the high-participation, low specialization category. Prior to the mobilization over the right to refuse treatment, legal representation on mental health issues was furnished through a variety of public and private sources with little coordination. There was no centralized organization or network of mental health lawyers. As for participation, mental patient liberation groups were more active in the part of California from which the right to refuse treatment litigation emerged than they were anywhere else in the country.

Two characteristics were much more important in the California mobilization than they were in any other case in this study. One is the tension that developed between the lawyers and the liberation groups over the amount of those groups' participation in the case, while the other is the degree to which the scope and pace of the California case was controlled by outside events.

A. *Policy Context: Legal Specialization Prior to the Right to Refuse Treatment Mobilization*

The California legislature was a pioneer in mental health reform. By 1972 it had expanded an already comprehensive set of rights-oriented policies to include the right of mental patients to see a patient advocate. In 1976 this right was implemented by the establishment of county mental health advocacy programs, with an average of one advocate for every five hundred thousand people. Counties could either hire their own advocates or contract the programs out to agencies (CAL. WELF. & INST. CODE ANN. § 5325(h) (West 1984)).

On the surface, then, public policy in California closely linked the development of rights with the need to make resources available to vindicate these rights, but this linkage was not as strong as it appeared. Despite the act requiring a patient advocate in each county, as late as 1978 Los Angeles County had appointed one only after the ACLU threatened to sue. State hospitals were also slow in setting up mental health advocacy programs of the kind required by the 1972 legislation

(United States Department of Health, Education, and Welfare, 1979: Appendix A, pp. 1–2). The state paid more attention to the physically disabled and the mentally retarded, although even in these areas implementation of federal and state laws was limited. Of the four states in the present study, California's protection and advocacy programs for the physically and mentally disabled defined their political activities the most narrowly (American Bar Association Commission on the Mentally Disabled, 1978). The Department of Health, Education, and Welfare's assessment (1979: Appendix A, pp. 1–2) stressed the weaknesses of these advocacy programs: "To quote the Mental Health Advocacy Project of Los Angeles County, 'the quality of care for mentally disabled persons is shockingly poor in California.' "

B. Policy Context: Lay Participation Prior to the Right to Refuse Treatment Mobilization

By the late 1970s there was an uneven mixture of legal representation and group participation in the California mental health rights movement. A brief look at this mixture in the San Francisco area, where the right to refuse treatment case emerged, gives an indication of its nature and its limitations.

The mental health advocacy organization that was mandated by the state legislature was not established in San Francisco until the late 1970s, which was after the emergence of the right to refuse treatment case (Patients' Rights Advocacy Services of San Francisco, [1980]). Prior to the case, an organization of attorneys sympathetic to mental patient liberation causes had formed, but this was a shoestring operation that never had the resources to reform laws. The same limitation was faced by a similar organization of University of California at Berkeley law students (*Madness Network News*, 1976a: 21; 1974: 11; 1972: 9). In effect, then, prior to the right to refuse treatment mobilization, there was no identifiable mental health bar. Mental health cases were handled by public defenders, who did not bring significant class actions.

Participation was a different story. By the mid-1970s the San Francisco Bay area had become a key part of the international network of mental patient liberation groups. The two most important regional groups were the Network against Psychiatric Assault (NAPA) and the Bay Area Coalition against Psychiatry (BACAP). Each was well established before the right to refuse treatment emerged as a legal issue in California. These organizations were heavily committed to mental patient

liberation ideology, and some of their members became nationally known as spokespersons for the liberation movement (e.g., Frank, 1978).

Representatives of these groups regularly contributed to the *Madness Network News*, a quarterly, founded in 1972, that was the communications focus of the international network of liberation-oriented mental patient views. BACAP and NAPA were also very active in local mental health issues, for both were genuinely grass-roots, self-help, and community-organization oriented. Many of their activists had received their political training in the late 1960s and early 1970s, so their tactics typically reflected the lessons learned in the protest politics of that earlier time (Milner, 1986a).[16]

These liberation groups were ambivalent about the use of litigation. The problems that they identified left some room for legal solutions, but the real issues were broader. For example, BACAP did not discuss the right to refuse treatment as much as it discussed "forced drugging" (*On the Edge*, 1979; 1980). NAPA was similarly concerned with the right to refuse treatment in a broader context that emphasized the need to end all involuntary treatment (*Madness Network News*, 1976b). There was the fear that litigation would become a tactic that artificially narrowed issues and unnecessarily drained resources. Expressing his discomfort with a right to refuse treatment approach, one supporter warned that such a right reinforced the notion that mental patients were very different from nonpatients in their rights and capacities. "The [real] issue," he said, "was human rights. The rights of the mentally ill should be the same as all others." Despite his misgivings, he defined the problem in terms of rights, and he ultimately agreed to participate in the development of the right to refuse treatment case.

Key events converted this concern about the legal system into even greater skepticism about its worth. In 1976, as a protest against forced mental patient labor, NAPA organized a sit-in in Governor Jerry Brown's office. The demonstration was well publicized, had ample participation, and ultimately led to a dialogue with the governor. During the sit-in, the issues broadened to include the right to refuse treatment (*Madness Network News*, 1976b).

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[16] BACAP and NAPA differed somewhat in their use of professionals, for BACAP accepted as members those professionals who were sympathetic to liberation ideology, while NAPA wanted only those who were former or present mental patients. These differences, however, did not affect their cooperation on major issues.

As a result of this demonstration, the state agreed to set up a task force and promised NAPA a $70,000 grant for a legal foundation emphasizing mental patient advocacy. NAPA members were split over whether the organization should accept these funds. Some members saw the offer as an attempt at cooptation. NAPA decided to take the money, but the state reneged. As one NAPA member remarked, "This really split the group. It probably was not a conscious effort on the part of the state, but it did split the organization."

Some legal activity continued after this incident. The *Madness Network News* ran a regular column on mental health law. But NAPA's and BACAP's involvement was sporadic. Litigation did not appear to be a very integral part of their strategies. Still, the idea of a right to refuse treatment remained important, even if the involvement in the legal process was limited.

C. *Legal Mobilization and the Right to Refuse Treatment*

The mobilization started very quietly. Neither mental patient groups nor mental patient liberation groups were involved in bringing the issue to the attention of the attorneys who ultimately took over the case. Instead, a few mental patients in Napa State Hospital, through intermediaries, got in touch with some attorneys. They all did this separately and were initially unaware of each others' contacts. One woman, who had been both a voluntary and involuntary patient for fifteen years and who suffered from the aftereffects of drugs, came in person to the San Francisco ACLU office.

A California legislative research assistant who had done some work on the right to refuse treatment brought the issue to the attention of this ACLU chapter. His legislative study was also noticed by a Golden Gate University Law College professor who was looking for a case that would help his students understand public interest litigation. Neither the ACLU nor that attorney had any experience with mental health law reform. Although the attorney had a good background in prison law, he had no contacts within the California mental institutions. The ACLU obtained the services of a San Francisco law firm to help the professor, but the firm's attorneys similarly lacked experience in mental health litigation. In January 1978 the professor filed the case under the auspices of the ACLU chapter and the Constitutional Law Clinic at Golden Gate Law College.

At the outset, the lack of legal specialization played a key role in the mobilization. The law firm's attorneys not only had

no litigation experience in the field, they also did not set foot in the mental hospital wards for the initial year of the case's development. The professor had to rely on a county public defender's office to get him into the hospital. Yet despite his lack of access and experience, the case was initially filed as a very broad class action that included all voluntary and involuntary mental patients in all California institutions licensed to handle the mentally ill under the California Code (*Jamison* v. *Larabee* No. C-78-0445-WHO (N.D. Cal. 1983)).

This choice of class actions was made for two reasons. First, the lawyers thought that it was advantageous to build a case that was analogous to the New Jersey and Massachusetts cases that had already begun to get some prominence. Second, the attorneys were optimistic about the federal courts' sympathies toward such broad and sweeping conceptualizations. As one lawyer put it, "We felt that the federal court decisions were encouraging or at least a blank slate. We also thought that the mental health law in California was too sympathetic to the medical model."

The combination of the class action approach and the limited access to those people whose troubles would ultimately be the basis of a class action created problems for the lawyers. They tried to resolve these problems by using the mental patient liberation groups as case finders. While BACAP and NAPA even formed a special organization called the Coalition against Forced Treatment (CAFT) to perform this role, they also wanted a greater part in developing the case. They had a well developed political agenda, and their experiences had made them wary of the pitfalls of letting litigation affect this agenda.

Early on, the attorneys and the liberation groups differed over how the issue should be defined. Some of the laypersons wanted to focus on closing the institutions. Others sought an absolute right to refuse treatment. The attorneys, on the other hand, saw the right as more important in itself. They did not want to attack the legitimacy of involuntary commitment. Instead, they wanted to concentrate on giving the maximum protection to those who had been committed in this way. The attorneys' views prevailed. Although at least initially the case was sweeping in regard to the kinds of people to which it applied, it was not, in the liberation groups' sense of the term, sweeping in the way the attorneys defined the issue.

Consequently, during these early stages of the legal mobilization, NAPA and BACAP remained skeptical participants. It is significant to see the distance that the *Madness Network*

News maintained from this California case in contrast to its approach to right to refuse treatment litigation elsewhere. For example, its 1975 article on the *Rogers* case in Massachusetts contained a profile of Rubie Rogers, a description of the events leading up to that case, and a discussion of the trial judge's initial order (*Madness Network News*, 1975: 7). The publication was never so sympathetic or detailed in its discussion of the California case. In the fall of 1980, well after the litigation had begun, it published a brief account of that case and the Colorado case, emphasizing the limits of the latter. There were no personal profiles (*Madness Network News*, 1980: 19).

The liberation groups' decreasing involvement could have increased the pace of the case by reducing dissension and giving the attorneys more leeway. Instead their partial withdrawal seemed to slacken the pace. The plaintiffs' lawyers and the state were able to negotiate regulations that applied only to voluntary patients at all mental institutions. Even the benefits to these patients were limited because of the delay in drafting these new procedures. To the liberation groups, this limited agreement was a reminder of the pitfalls of the legal process. The groups decided to take actions that would strengthen or at least quicken the pace of implementation of the agreement between the state and the plaintiffs. BACAP drew up an informed consent policy for San Francisco public mental health centers. The centers promised to implement the regulations by April 1, 1981, but did not. In response, BACAP threatened "direct political action" (*On the Edge*, 1981).

The liberation groups saw this inaction as one more in an increasing parade of events that showed the ineffectiveness of litigation. They were disappointed not only with the scope of the initial agreement but also with the process of the negotiations. As one participant stated, "The lawyers should never have settled. The agreement is riddled with holes. We were not a part of the decision." By themselves, however, the liberation groups did not have the political or financial resources to overcome either the limits of the litigation or its inertia. At the same time, the lawyers did not have a well developed alternative network that could replace BACAP-NAPA coalition's access to the mental hospitals.

Still the case did not go to trial, and the attorneys continued to try to work out an agreement on the central and most difficult issues, which applied to involuntarily committed inmates. The patterns of legal specialization played another role in the decision to move the case slowly, for besides the absence of case finders, there was no network of sympathetic doctors

and lawyers. The sheer size of the class thus became a real obstacle to obtaining information. But the momentum and scope of the case also slowed for reasons having little to do with patterns of legal representation or participation.

From the beginning, the federal district court judge was reluctant to let the case go to trial. He refused to allow the attorneys even to begin discovery and instead insisted that the parties continue to negotiate.[17] When it became apparent to the lawyers for the mental patients that negotiations were not going to be successful, the attorneys decided to delay the case to await the United States Supreme Court's decision in either the New Jersey or Massachusetts cases. When it became clear the Court was not going to make a definitive decision on either of these cases, the California attorney general suggested an approach that appealed to the patients' lawyers, who by now had fewer resources for and less optimism about maintaining a class action law reform litigation. As one of these formerly hopeful attorneys stated, "The federal courts are increasingly less sympathetic about these issues. Even if we won on appeal, the Supreme Court would destroy any attempt at a broad right to refuse. We want to get out from under the federal constitutional issues and get what we can."

The state attorney general suggested that the scope of the class be reduced to include only nondangerous, involuntary patients in Napa State Hospital. This appealed to the patients' chief litigator because his connections were strongest with that institution, although it contained only a small fraction of the involuntarily committed mental patients in California. In the early spring of 1983 the attorney general received permission from the State Department of Mental Health to modify this plan along the lines of the *Rennie* decision in New Jersey. Given the alternatives as they saw them at this time, the attorneys agreed to settle and to bring any future litigation in the state courts. The case was settled in the summer of 1983 (*Jamison* v. *Larabee* No. C-78-0445-WHO (N.D. Cal. 1983)).

Not long before the final settlement, tension between the attorneys and the liberation groups had increased sufficiently to jeopardize a trial even if the lawyers had been unwilling to settle. During the spring of 1983 the liberation groups were ac-

[17] One of the plaintiffs' lawyers claimed that the trial court judge had been so frightened by the three dozen or so present or former mental patients who were in the courtroom during the first day of the hearing that he stalled the trial to avoid the pressure of having these people in court every day. None of these spectators or defendants disrupted the court in any way.

Table 1. Patterns of Legal Specialization, Lay Participation, and the Scope and Pace of Legal Mobilization

	Legal Specialization	Lay Participation	Pace (Rank)[a]	Scope (Rank)[b]
Colorado	low	low	1	4
New Jersey	high	low	2	1.5
Massachusetts	high	high	3	1.5
California	low	high	4	3

[a] Composite rankings were based on when the case was filed, time between changes in mental health law and case filing, and final disposition by trial court.

[b] The narrower the scope, the lower the rank, e.g., Colorado ranks fourth because the case never involved class action.

tive in a campaign to pass a referendum making it illegal to use electroshock therapy in Berkeley. These organizations wanted the attorneys in the right to refuse treatment case to support the referendum, but they refused because they thought such a position was inconsistent with the freedom of choice approach they were planning in the case. They were not willing to argue in one context that individuals with serious emotional problems had the competence to make informed choices about drugs while in another very visible situation claim that such people could not make their own decisions about the usefulness of shock treatment. For the litigators, the case had to take precedence.

The liberation groups had always held that the right to refuse treatment was part of the larger issue of psychiatric oppression and consequently felt that the attorneys' unwillingness to support the referendum was another example of how the legal process could artificially narrow issues and coopt those who sought to get at the root of the problem. Had the case gone to trial, both NAPA and BACAP would have backed away. More significantly, one of the key witnesses for the institutionalized mental patients said that he would no longer testify because the lawyers would not support the referendum (Milner, 1986a).

VI. COMPARATIVE ANALYSIS: SPECIALIZATION, PARTICIPATION, AND OUTCOME

In this section we will compare the contributions that the patterns of legal specialization and participation made to the scope, pace, and outcome of the four right to refuse treatment mobilizations. This analysis will suggest some general propositions about the relationship between the patterns and results of legal mobilization.

A. Some Propositions

The two left-hand columns in Table 1 list the extent of participation and mobilization for each of the four cases, while the other two columns rank the cases according to outcome. There appear to be several links among mobilization patterns, scope, and pace:

1. *Mobilization with the fastest pace emerges when there is a low degree of legal specialization and a low level of lay participation.* Colorado is the example of this, for its case assumed an early straightforward thrust that was never really threatened. The structure of legal representation discouraged the more complicated class actions, and because there was limited lay participation, the lawyers felt no outside pressure to define the case as anything but a legally routine action involving one plaintiff represented by a private attorney.

2. *Mobilization with the slowest pace emerges when there is a low level of legal specialization and a high level of lay participation.* The California mobilization, which manifested this pattern, was clearly the slowest. While mental patient politics in the state encouraged a broad approach to the right to refuse treatment issue, the structure of legal representation limited the available resources. The absence of case finders and a professional network to whom the litigators could turn for advice further slowed the pace. Interest groups like BACAP and NAPA played a role in partially overcoming these obstacles, but the groups' goals and strategies did not reinforce the lawyers' approach, and in time the groups became disenchanted. Ultimately the attorneys developed a strategy that purposely slowed the case, but this decision was made partially because of the problems that were directly related to the limits of the legal representation and because of the friction between the lawyers and the liberation groups.

3. *Mobilization with the broadest scope emerges when legal specialization is high, although the degree of lay participation may vary greatly.* The key factor in developing broad mobilization is a high degree of legal specialization, as seen in New Jersey and Massachusetts, both of which had the broadest scope. In New Jersey the resources were furnished through a centralized, specialized legal organization that had an institutionalized access into the state mental hospitals as well as the resources and rules for class actions. In Massachusetts, the specialization was not as centralized nor clear-cut. Strictly speaking, although the state's most specialized legal organization did not have jurisdiction over the place in which the mobilization

emerged, it did have a regular working arrangement with the legal services attorney who first brought the case in Boston. In addition, the Boston Legal Services office had a mental health law specialist with much experience working in the institution in which the case developed.

Although these two mobilizations had very different levels of lay participation, participation is not necessarily an unimportant factor in determining the scope of mobilization. The structure and specialization of legal representation in New Jersey did not simply encourage class actions but also greatly reduced the need for outside resources to help develop such cases. Indeed, from the standpoint of organizational authority, there were advantages for the New Jersey mental health advocate's office in keeping the case in-house.

The situation in Massachusetts was quite different and illustrated the variety of roles laypersons or organizations might play. There the MPLF was not initially important as case finders because the seven patients did the early organizing. Nor was the MPLF initially supportive of a class action. As the mobilization developed, however, the MPLF became more convinced of the need for a class action, and helped the attorneys mobilize the patients into this legal strategy, thereby playing essential roles as intermediaries and case finders.

Thus it appears that mobilizations with the widest scope do not develop unless a high degree of legal specialization is available, although this specialization alone may not be sufficient to bring about a class action. Also essential is a case-finding, intermediary network, which may be institutionalized by the state (New Jersey) or develop through active lay participation (Massachusetts).

4. *Mobilization with the narrowest scope emerges when legal specialization and lay participation are both low.* Colorado again is the example, because the same factors that encouraged a quick mobilization discouraged a broad one. There were no resources for class action and no lay pressure to move in that direction.

5. *There is a tension between the pace of mobilization and the degree of lay participation.* The mobilizations with the lowest participation were completed most quickly. This is consistent with other mobilization patterns, especially when professionals are involved. When professionals are allowed to work essentially unimpeded by lay interest groups, policies emerge quickly. When such groups are involved, the process often slows down because there are more competing notions about

what should be done and how to do it. Professionals are then frequently accused of being patronizing, manipulative, or authoritarian by having defined the problem too cautiously, too technically, or too narrowly (Milner 1986b; Frieden and Kaplan, 1975; Crain, Katz, and Rosenthal, 1969).

On the other hand, there is evidence that under some circumstances a high degree of interest group activity fosters mobilization (Alford and Scoble, 1969: 184–192). Also, the pace of the mobilization is not necessarily the most important indicator of success. Because the scope is certainly also important in the right to refuse treatment mobilizations, we should explore the accommodations between pace and scope.[18]

B. Models of Legal Mobilization

Legal mobilization is thus an adventure—a problematical enterprise that is much affected by patterns of legal representation and lay participation. The dimensions of specialization and participation suggest certain legal mobilization models that highlight different patterns of these important variables. The models also feature norms that color the actions in each of the patterns. Further, the models suggest the different mobilization patterns, the sources of tension in each pattern, and the way such tensions may be mitigated.[19]

One model, exemplified by Colorado (low specialization, low participation), is *consensual mobilization*. Such mobilization depends on norms that emphasize shared perspectives and common values. The strategic question in this kind of mobilization is, "Do the strategies reflect common values?" Consensual mobilization is problematic to the extent that there is disagreement over whether that question can be answered affirmatively. In Colorado, there was no such disagreement.

A second model, exemplified by New Jersey (high specialization, low participation), is *bureaucratic mobilization*. In this

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[18] Perhaps legal mobilization can be considered a process of tradeoffs in attempting to reach an optimal balance between scope and pace. If so, then Table 1 suggests the proposition that mobilizations with a high degree of legal specialization accommodate these tensions better than their counterparts do. If we develop a ranking based on the composite of the pace and scope scores in Table 1, New Jersey and Massachusetts have the highest rankings, that is, there is greater similarity between pace and scope of their mobilization. Even if the proposition holds, we must remember how different the participation patterns in these two cases were. In any case, the proposition is very tentative. It is primarily valuable because it suggests the need to consider more systematically the tradeoffs and accommodations of legal mobilization.

[19] Here I have borrowed extensively from Alford and Scoble's (1969: 31–33) "strategic models of the political process." These models go beyond my concern here, but they are useful because they are built on a participation-specialization dimension.

pattern professionals have a shared interest that is independent of citizen competence. However, they are not unfettered because they work in organizations that hold them accountable to rules. The norms of this type of mobilization focus on these rules. The key question determining the problematic nature of bureaucratic mobilization is, "Are the rules governing strategies and resource allocation being applied fairly by the professionals?" In New Jersey, the mobilization did not become problematic because the decisions made by the public advocate's office were perceived to be consistent with the organization's rules and because the strategies of the advocate's office stayed within the basis of that organization's authority as an "inside" agency.

Marketplace mobilization is a third model, of which California is an example (low specialization, high participation). Here legal professionals are not strongly enough situated to control mobilization themselves. Instead they act as arbiters of interest group activity, which is high. Legal specialization is low, so there is no body of organizational rules that both protects the professionals and helps insulate them from citizens. The key question is, "Do the legal professionals allow the groups freedom and access to bargain about the mobilization?" In California, mobilization became at least partially problematic because the mental patient groups thought they had lost that access.

The fourth model, as shown by the Massachusetts case (high specialization, high participation) is called *voluntary association mobilization*. In this model there are strong expectations of participation as well as a strong sense of competence among the legal professionals. Since so many groups expect to get into the act, consensus building becomes a key activity and the source of the main problem. The crucial question here is, "Are the lawyers trying to build consensus, or are they going off on their own?" Consensus building was apparent at all stages of the Massachusetts mobilization.

C. *Additional Factors That Affected the Mobilizations*

The case studies also showed that factors other than representation and participation were important to the development of mobilization. Many were related to the fact that the cases began at different times, for with time the sophistication of both the plaintiffs and the states increased. Colorado's case was initially decided so easily partially because the state mental health bureaucracy had little idea how to respond. This should

be compared to the carefully developed responses of the California attorney general's office. Also, as more cases developed, lawyers learned from each other. For example, the New Jersey case became a guide for the California settlement. Resource problems also greatly affected the development of mobilization. When resources diminished in California due to Proposition 13, so did the optimism that funds would be available to implement institutional law reforms.

The attitudes of the trial judges also differed. The Colorado judge did not encourage a class action, and the California judge definitely discouraged one, while their New Jersey counterpart actively encouraged a case of this scope. Perhaps the judges' actions were related to the structure of legal representation: In both California and Colorado, there were limited legal resources for bringing a class action, whereas a different situation existed in New Jersey.

With the exception of Colorado, where the case began in the state courts, the greatest change for the attorneys over time was that all became more pessimistic about the chance for successful law reform litigation in the federal courts and acted accordingly. The California case had begun late enough to have this pessimism affect pretrial settlement strategy, while in Massachusetts, the attorneys put the brakes on a case already before the United States Supreme Court.

VII. CONCLUSION

I would not claim that patterns of legal specialization and lay participation are the only determinants of the outcome of mobilization. However, I have shown that these patterns had a sufficient impact on the pace and scope of mobilization to warrant comparative analysis of these variables. Through the case studies and such analysis I have tried to demonstrate the importance of these two factors. Ultimately, this work is most significant as an exploratory study that should generate further inquiry because it suggests the following:

- a set of characteristics that should be investigated in other studies of legal mobilization;
- a perspective that considers legal mobilization along lines similar to those explored in studies of other kinds of political mobilization;
- a series of mobilization models that identifies the various sources of friction and uncertainty in legal mobilization; and
- a confirmation of the effect of preexisting patterns of legal representation on the scope and pace of legal mobilization.

APPENDIX
Profiles of Right to Refuse Treatment Mobilizations

Location	Year Mental Health Law Reformed	Year Case First Filed	Scope at First Filing	Later Scope	Year of First Disposition	Trial Court Decision	Last Apellate Court Decision	Disposition, 1983
Colorado	1973[a]	1977	Individual	Individual	1977[e]	1977	1977	Completed by 1979 in state supreme court
New Jersey	1975[b]	1977	Individual	Class	1977[e]	1978	1982	Asked U.S. Supreme Court to hear
Massachusetts	1970[c]	1975	Small group	Class	1975[e]	1979	1980	Remanded by U.S. Supreme Court
California	1969[d]	1978	Class	Class but much smaller than original	1978[f]	Case settled	n.a.[g]	n.a.[g]

[a] COLO. REV. STAT. § 27-10.5, 110–130 (1973, 1977).
[b] N.J. STAT. ANN. § 30:4–24.1 (West 1981).
[c] MASS. GEN. LAWS ANN. ch 123, § 23, 25 (West 1982).
[d] CAL. WELF. & INST. CODE ANN. § 5150, 5325, 5326, 5327 (West 1972); § 5325 (West 1984).
[e] Preliminary injunction restricting forced medication.
[f] Judge ordered parties to negotiate.
[g] n.a. = not available.

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